

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

23217.

1. PLACE OF DEATH

County Jackson Registration District No. 404
 Township Kate Wash Primary Registration District No. 5558
 City Kennett (No. 7901 Brookside Rd. St. _____ Ward)

File No. _____
 Registered No. 57

2. FULL NAME

James Braselton Adams
 (a) Residence No. 7901 Brookside St. Ward. 8
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary M. Adams

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1-1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 2 1

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Coal Dealer
 (b) General nature of industry, business, or establishment in which employed (or employer). Self.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cicero
 (STATE OR COUNTRY) Indiana

10. NAME OF FATHER Isaac Adams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cicero
 (STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Mrs. Blessing

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT William N. Adams
 (Address) 7901 Brookside Road

15. FILED 7.8.1930 R. F. Rainard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 2 1930

17. HEREBY CERTIFY, That I attended deceased from June 10 1930 to July 2 1930, and that I last saw him alive on July 2 1930, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular Insufficiency
92A

CONTRIBUTORY (SECONDARY) 900
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH at place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) J. V. French, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
1/2 1930 (Address) 410 H 75 78 C Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Indianapolis Ind. DATE OF BURIAL July 4 1930

20. UNDERTAKER Eylar Funeral Home ADDRESS K.C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S opinion state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Res. 500 W. 74 Ja. 1868